ARKANSAS

ARKids First Operational Protocol

1. The organizational and structural administration that will be in place to implement, monitor, and run the demonstration, and the tasks that each will perform.

   The Department of Human Services, Division of Medical Services (DMS) is the primary agency responsible for the waiver. In collaboration with the Department of Human Services, Division of County Operations (DCO), DMS will implement, monitor and administer the demonstration. DCO will be responsible for eligibility determinations. Staff in the Arkansas Division of Medical Services including Program Planning and Development, Medical Assistance, Utilization Review, Financial Activities, Systems and Support and Prescription Drug Sections have been designated to perform the necessary tasks outlined in the Special Terms and Conditions.

   The DMS contact for the waiver is Ray Hanley, Director, Division of Medical Services, Post Office Box **1437** - Slot **1100,** Little Rock, Arkansas **72203-1437.** His telephone number is **(501) 682-8292** and his fax number is **(501) 682-1197.**

2. **A** complete description of Medicaid services covered under the demonstration.

   Refer to Attachment **1** for a complete description of services covered under the ARKids First Program.

3. **A** detailed plan for monitoring the State's coordination of care between the PCP and other entities such as public health departments, school-based clinics, etc.

   PCPs are able to track all Medicaid-covered services their patients receive. The Title XIX fiscal agent generates and distributes monthly, to each PCP, a Primary Care Physician Utilization Report, unique to each PCP's practice.

   Arkansas Foundation for Medical Care, Inc., (AFMC) rates PCPs with respect to their patient's use of Medicaid services. AFMC distributes contract with the State, effective September **1,1997,** AFMC will also review records of the PCPs whose ratings indicate over-utilization or under-utilization of services. AFMC will review patient records of providers to whom those PCPs refer patients. AFMC will determine whether referrals are appropriate, whether the referred-to providers appropriately furnish requested services, and whether PCPs and providers to whom PCP's refer patients communicate among themselves sufficiently to enable the PCP to effectively and economically perform case management.

4. **A** description of the State's beneficiary education and outreach processes, including the availability of bilingual materials/interpretation services.

ConnectCare is Arkansas Medicaid's managed-care program which includes an effective outreach and beneficiary education component. The program gives Medicaid patients, including the ARKids First populations, access to mainstream, private-sector medical care: Each Connectcare patient chooses a primary care physician to provide routine and preventive care and to refer that individual to other health care providers, such as medical specialists, when appropriate.

Because Arkansas Medicaid has made it easy for health care providers and recipients to participate in Connectcare, about 82 percent of the **185,000** Arkansans who are eligible for the program already are enrolled. All others who are eligible will be enrolled as they seek health care. Medicaid patients are informed about Connectcare by physicians, television public service announcements, and a 24-hour hotline sponsored by the Arkansas Department of Health.

Connectcare is currently developing brochures in Spanish expected to be ready for distribution to the ARKids First populations by the time the program is operational in September. Since each ARKids First recipient must participate in the Connectcare Program, all outreach materials designed for Connectcare will apply. The 24-hour hotline maintained by the Arkansas Department of Health has access to Spanish speaking interpretative services, a Spanish healthcare directory for assisting the caller with Arkansas health services and various healthcare brochures in Spanish to assist with the selection of and accessing the healthcare system.

In addition to those outreach services provided by the Arkansas Department of Health, the Division of Medical Services has contracted with an Arkansas advertising and public relations firm to develop media outreach for the ARKids First Program, in anticipation of its approval. The purpose of the contract is:

- to produce and implement a statewide media plan to increase awareness of ARKids First, using radio, television and print advertising
- to design and produce print and video materials associated with the outreach and public education needs of potential ARKids First program users
- to design the ARKids First logo
- to manage a fixed dollar budget for each year of the program
- to plan and implement promotional opportunities at community events and help schedule DHS officials and Governor's office representatives as speakers at these events

In addition to the media and advertising components, the contractor will be required to develop an easy to read recipient brochure. The brochure will describe the program, the eligibility processes, the benefit plan including the co-insurance, how to access healthcare and the appeal rights from any decision of the State in determining eligibility or claim denial. This packet will be made available to each person seeking an application to the ARKids First Program or provided to anyone with interest in the program. It is designed to be an aid to accessing care, and written for the average user of healthcare services avoiding the jargon associated with most governmental or insurance programs.

A toll-free number will be published in all media presentation which will be answered by **a** DMS staff trained to respond to coverage, eligibility and appeal questions. The staff of the DMS 1-800 line will also be able to route the caller to the ConnectCare hotline, or the eligibility unit's hotline to quickly respond to the caller's needs.

Through the combined efforts of the local Health Department offices, the Department of Human Services offices and the provider and interested party partners (speaker's bureaus, civic clubs, churches, temples and synagogues) all printed materials and telephone hotline numbers will be available in every part of the state of Arkansas.

5. **A** comprehensive description of the enrollment and disenrollment processes.

All individuals who wish to apply for ARKids First will be given the opportunity to do so without delay. No application or inquiry will be ignored. The Division of County Operations has the responsibility to follow up on any request for medical assistance and to make arrangements for providing an application.

The enrollment process will require the completion of **a** simplified application form by the individual, adult relative, custodian, guardian, or representative of an institution if the individual is court ordered to **a** facility. If emancipated, the minor must sign the application. If **a** child has been court ordered to an institution, **a** representative or designee of the institution must sign the application.

The application form will be available at DHS county offices, local health units, or by mail, if requested. To request an application by mail, an individual may call **a** toll-free hotline (voice or TDD). Application forms will also be made available to churches, licensed day care centers, hospitals and institutions, selected physicians' offices, clinics, public schools, community neighborhood centers, and pharmacies, if they request a supply of forms.

After completion, the application form (along with proof of Social Security enumeration, age, and income), will be mailed by the applicant or by a DHS county office, if requested by the applicant, to the ARKids First Central Office Eligibility Unit, Post Office Box **5701,** North Little Rock, Arkansas **72219-5701,** for processing.

Referrals to the **ARKids** First Central Office Eligibility Unit may also come from DHS county offices. If one or more children of **a** Medicaid applicant are determined ineligible for non-waiver Medicaid by the county office, and it appears that they may be eligible for ARKids First, the county office will refer the case to the ARKids First Central Office Eligibility Unit for an eligibility determination.

Conversely, referrals to county offices may come from the ARKids First Central Office Eligibility Unit. If any or all children of an ARKids First applicant appear eligible for Medicaid in another category, the central office worker will contact the applicant and ask if he or she would like to file an application with the DHS county office. If so, the worker will refer the case to the DHS county office in the applicant's county of residence for an eligibility determination.

To be enrolled for services in the ARKids First category, the following criteria must be met:

- Age: Each participant must be under age **19;**

- Relationship and Living with Specified Relative: Each participant must live with **a** relative, unless he or she has been removed from the custody of his or her parents by court order, has been court ordered to an institution, has been emancipated, or legal custody has been given to someone else;

- Citizenship or Alien Status: Each participant must be either **a** U. S. Citizen or **a** qualified alien;

- Social Security Enumeration Reauirement: Each participant whose needs are included in determining eligibility must be enumerated or must apply for enumeration;

- Mandatory Assignment of Rights to Medical Support/Third Party Liability: Each participant must assign their rights to medical support/third party liability to the state;

- Referral to the Office of Child Support Enforcement (OCSE): A child support referral must be made on the absent parent of a participant (or on a parent for whom paternity has not been established). ARKids First participants who are pregnant are not required to cooperate with OCSE for their children, but an absent parent of a pregnant participant must be referred;

- Residence: Each participant must be a resident of Arkansas;

- Income: Total gross income must not exceed 200% of the Federal Poverty Income Guidelines for the appropriate family size; and

- Health Insurance: Children who have been covered by primary comprehensive health insurance, other than Medicaid, within the 12 months preceding the date of application will not be eligible for services (unless insurance was lost through no fault of the applicant).

Enrollment will take place continuously throughout the duration of the project. No change reporting requirements exist, but cases will be reevaluated fully after one complete year of coverage to determine continuing eligibility. Loss of eligibility may occur at any time if the participant fails to meet any of the above listed criteria (except income, for which changes are not considered during the 12-month certification period).

6. An overall quality assurance monitoring plan that includes a discussion of all quality indicators to be employed and methodology for measuring such indicators; surveys to be conducted, and the monitoring and corrective action plans to be triggered by the surveys; credentialing requirements and monitoring; fraud control provisions and monitoring; and the proposed provider-enrollee ratios, access standards, etc.

Arkansas Medicaid is embarking upon an innovative quality assurance process for all participants in Arkansas' managed care plan, Connectcare, effective September 1,1997. This process will be administered by a key partner with Arkansas Medicaid, the Arkansas Foundation for Medical Care, Inc. (AFMC), Arkansas' federally certified peer review organization. The AFMC brings to the partnership extensive expertise: - Quality assurance of health care through its approximately 30 years of responsibility for oversight of Medicare services in Arkansas. Included in the process is monitoring and evaluation of both primary care and specialty provider activities, consumer feedback and satisfaction and overall evaluation of improvement in both the health care services delivered to Connectcare participants and the individual health of each participant.

The following are the deliverables of the AFMC Managed Care Services Division.

A. Ongoing utilization review and analysis of quality of care for primary care and subspecialties.

The AFMC, through sample analysis, will review service patterns of individual primary care providers including referrals to determine both appropriateness and cost effectiveness. Included will be an analysis of the demographics of a particular PCP's caseload, i.e. children, efforts to provide outreach for preventive care such as health screenings and immunizations.

PCPs who fall below standards as required by program and policies will be subject to education by the AFMC's medical staff, including physicians.

B. Onsite Visits. Onsite visits will be conducted at a percentage of primary care providers offices to examine both documentation and facilities available for Connectcare participants. Included will be personal contact by AFMC to determine primary care providers understanding of program requirements, revisions, etc.

C. Customer Satisfaction. The AFMC will conduct at least two surveys each year of Connectcare participants to determine customer satisfaction. Particular attention will be addressed to questions of access and participant needs that may not be addressed by their primary care provider. Results will be compiled and where necessary educational interventions will be initiated.

D. Data Collection and Analysis. Quarterly the AFMC will produce the primary care physician performance report that will document individual PCP performance versus the peer standards. Items of importance in this analysis will examine both over and under utilization, including office utility, emergency room utilization, preventive health screenings and immunization levels. Summary reports will be made to the state agency.

E. Health Care Quality Improvement. An innovative piece of the AFMC services will be the analysis of individual primary care providers practices to establish preferred practice patterns for all PCP's providing services to Connectcare participants. An integral part of this process is the continuation of the AFMC's health care quality improvement processes which in the past have examined and reported C-Section delivery patterns and other areas of quality medical management.

Both the Arkansas Department of Health (another Connectcare partner) and Arkansas Medicaid will maintain a toll free hot line for consumer complaints regarding recipient complaints. Provider complaints may also be addressed through a separate toll free hotline for the Arkansas Medicaid Program.

7. Description of how claims data file would be made available to an evaluator.

The claims data file will be available in the format requested by the evaluator. The State will comply with the General Requirements outlined in Attachment B, Item **1,** in the Special Terms and Conditions.

8. The complaint and appeal policies that will be in place at the State level.

Recipient appeals are available through the ongoing Appeal and Hearings process offered to recipients of services by the Arkansas Department of Human Services of which Arkansas Medicaid is **a** division.

An applicant will be given the opportunity to appeal the denial of coverage under the demonstration or the failure of the Agency to process the application within **45** days. A participant will be given the opportunity to appeal when he or she is aggrieved by any Agency action resulting in the reduction or discontinuance of assistance. A hearing will not be granted when either state or federal law requiring automatic reductions in medical assistance occurs which affects some or all participants. A request for a hearing must be received in the Appeals and Hearings Section of the Department of Human Services (DHS) no later than 30 days from the date of the advance notice of reduction or termination.

When an applicant or participant (or his or her designated representative) wishes to request a hearing, he or she may do so by completing an "Appeal for Hearing" form (available in DHS county offices or by contacting the ARKids First Central Office Eligibility Unit) or by making his or her request by letter to the Appeals and Hearings Section. If a participant files an appeal for a hearing within the 10 day advance notice period (five days in case of probable fraud), the case will remain open until the hearing is conducted.

9. Basic features of the administrative and management data system.

Administration and Management of Data Services is accomplished in **a** highly effective, efficient and economical manner by use of the following three technologies: the Medicaid Management Information System (MMIS) and fiscal agent contract;

the Automated Eligibility Verification and Claims Submission (AEVCS) Subsystem; and, the Arkansas Medicaid Decision Support System.

Medicaid Management Information System and Fiscal Agent Contract

The MMIS and fiscal agent contract is the foundation of these three technologies. It assures that intensive computer intervention and concentrated administrative support services are applied to ARKids First claims processing administration, management and control. The MMIS is written in the COBOL programming language and now has well over **2,000** programming modules and more than **2.4** million lines of source code. A series of on-line programs give users the ability to view information from greater than **50** different computer screens. Many of these screens are on-line updateable. Additionally, there are several hundred production/procedural statements necessary to successfully execute the MMIS. The MMIS has ten subsystems which are fully certified by HCFA: Recipient, Third Party Liability (TPL), Provider, Child Health Services (formerly EPSDT), Long Term Care (LTC), Reference, Claims, Management and Administrative Reporting (MAR), Surveillance and Utilization Review (SUR) and Automated Eligibility Verification and Claims Submission (AEVCS) **.** The system has been in place in Arkansas Medicaid since October of **1985.**

Since March of 1996, the MMIS has undergone extensive enhancements which are intended to build upon it's already strong functionality. Some of these enhancements include the addition of: a Medicaid Local/Wide Area Network (LANNVAN) which provides state of the art technology to the desktops of most Medicaid employees; County Office Data Access which provides LANNVAN inter-connectivity to all of the Department of Human Services; table driven edits and audits to make that process more effective and efficient; and, GMIS Claim Check to further strengthen edit/audit management. Other enhancements include: digital Medicaid report storage and retrieval, automated drug rebate processing and prospective drug utilization review.

There are **160** fiscal agent staff assigned to provide administrative and technical support to this computer operation. These employees are organized within the following areas: Provider Relations, Claims, Systems, State Support/Quality Assurance and Health Care Services. Included are **25** programmers and **12** business analysts, with appropriate managerial staff, that will allow fast and effective maintenance and modification of the MMIS. These support services, with oversight and direction from the Arkansas DHS Division of Medical Services, assure effective program administration and management.

Automated Eligibility Verification and Claims Submission Subsystem

The AEVCS is **a** comprehensive system that augments the MMIS through the use of electronic claim capture and electronic claim management technology. It became operational statewide on June 30,1993. The system is available in over 3,400 provider locations across the State of Arkansas.

The AEVCS allows immediate eligibility determination and claims submission, All claim types used in the Medicaid program are supported. By the use of point of sale (POS) devices, an On Line Transaction Processor (OLTP) and a nation wide packet switching network, providers are now benefiting from easy and quick submission of medical claims along with some of the fastest processing times in the health care industry.

The AEVCS not only allows easy, fast and accurate medical claims processing, it also provides the infrastructure to attract **a** large pool of medical providers for the Arkansas ***Connect*** Care program.

Connect Cure is the Arkansas Medicaid primary care physician program.

The AEVCS also provides a state-wide electronic network through which recipients can request and be linked automatically to their Medicaid primary care physician. Once this is achieved in the MMIS and AEVCS, the benefits of managing access of recipients to specialty services and creating effective control of the program is realized. This adds another cost effective dimension to the administration and management of data services in the Arkansas Medicaid program.

Arkansas Medicaid Decision Support System

The Arkansas Medicaid Decision Support System is **a** comprehensive, integrated approach to the overall administration and management of data services. It includes an Executive Information System, virtually unlimited ad hoc reporting capabilities, statistical analysis, geographical information capabilities and quality program effectivenesslefficiency measurement and medical risk management. These tools will allow Arkansas Medicaid analysts to promptly answer any Medicaid management question.

This has been achieved by building **a** relational data base management system which uses the star schema multidimensional data warehouse approach to include virtually all data elements present in the Recipient, Provider, Claims and Reference Subsystems of the Arkansas MMIS. The system runs on two high capacity

minicomputers and provides three years of comprehensive, historical information. The interfacing tools include the products ***Business Objects, Codman Pandora Managed Care Information System*** and ***MAP Info.***

10. Description of procedures related to the State's financial reporting process.

The Arkansas Department of Human Services financial management systems operate under authority and control of two major State-operated financial procedures. The Arkansas Accounting and Budgetary Procedures embody all the various financial laws and prescribes the processes by which all State agencies budget and track expenditure, process payments, develop and monitor contracts, and manage funding and are compliant with the General Accepted Accounting Principles and the Generally Accepted Financial Reporting standardized principles.

In addition to the Accounting and Budgetary Procedures, the Department of Human Services has promulgated the Department of Human Services Financial Procedures which "establishes procedures for all financial undertakings in the Department of Human Services. It is intended for use by all DHS divisions, offices and institutions, both for interacting with the Division of Administrative Services and for developing and executing other internal financial procedures" (Summary from Manual Transmittal Memorandum dated December 15,1995). (The Arkansas Accounting and Budgetary Procedures and Department of Human Services Financial Procedures Manuals are available by request.)

Arkansas Medicaid's Fiscal Agent, Electronic Data System, Inc., operates the State's Medicaid Management Information System (MMIS) described in an earlier section of this Protocol. This system follows a general systems design approved by HCFA for the purpose of reporting financial transactions within the Medicaid system. In addition, the newly operational Decision Support System will allow ready analysis of financial transactions within the ARKids First Program, ranging from tracking expenditures to evaluating the utilization of services, the costs and usage of various programs and the overall financial condition of the demonstration.

The Division of Medical Services is responsible for the operation of the program including the financial management of ARKids First. The Division is assisted by the Division of Administrative Services which completes the quarterly HCFA-64 and HCFA-64.9. In addition to the HCFA-64 and HCFA-64.9, the State has planned modifications to many MARS reporting to specifically track the financial activity of the ARKids First Program. All changes to the MMIS and contemplated prior to or immediately following the demonstration waiver approval anticipated before September 1,1997.

Financial information similar to that submitted as part of the waiver application to illustrate budget neutrality can be produced on an "as-needed"basis.

11. Description of all referral authorization plans, and policies and procedures relating to them.

Referral/Authorization

As noted on the ARKids Medical Care Benefit Description, most services provided to ARKids First participants require a referral from the primary care provider in order for reimbursement to be considered. Referrals may be made by the primary care provider either in writing or by telephone contact, whichever is agreed upon mutually by the PCP and the receiving provider. Arkansas Medicaid policy simply stipulates that the record documentation of **a** provider billing for **a** service must clearly reflect that **a** referral did occur, from whom and for what purpose(s). It is expected that the receiving provider will provide feedback as to what occurred as **a** result of their treatment/service.

The necessary element for request for **a** referral service is the indication of the primary care providers Medicaid provider number in the claim submission process.

Fraud and Abuse

All services reimbursed through the Arkansas Medicaid Program including primary care through Connectcare for ARKids First eligible participants will be subject to Arkansas Medicaid's utilization review and fraud/abuse procedures.

As services are reimbursed upon **a** fee for service system (FFS) Arkansas Medicaid will continue to use the Surveillance Utilization Review subsystem of the Medicaid Management Information System to conduct quarterly analysis for monitoring and compliance. All cases identified for overpayment will continue to be referred for further analysis by the Arkansas Attorney General's Medicaid Fraud Control Unit for potential fraud.

In addition, Arkansas Medicaid will continue to conduct monthly Explanation of Medicaid Benefit surveys to include ARKids First participants to ascertain on **a** sample basis if services paid for **a** particular participant were in fact provided and if any additional payment beyond the co-pay **was** collected by the provider. Options include targeting **a** particular provider suspected of fraud and abuse.

All memorandums of understanding between the Arkansas Department of Human Services and appropriate federal/state agencies will apply to the ARKids First participant services for fraud/abuse investigations, including the provision of the Medicaid provider agreement to make records available to these parties.

ARKids First Medical Care Benefits

Program Services	Coverage Limits on Benefit	Prior Authorization/ PCP Referral	Copayment/ Coinsurance
Inpatient Hospital	Medical Necessity	PA on stays over 4 days	20% of first inpatient day
Outpatient Hospital	Medical Necessity	PCP referral	$10 per visit
Physician	Medical Necessity	PCP referral to specialist and inpatient professional services	$10 per visit
Vision Care *	1 visit per state fiscal year (July 1 through June **30)** (Routine exam and diagnostics)	None	$10 per visit
Dental Care * (No Orthodontia)	2 visits per state fiscal year (July 1 through June 30)(cleaning/full X-ray/restorative)		$10 per visit
Eyeglasses	One pair per state fiscal year (July 1 through June **30)**		None
Immunizations	All per protocol	PCP or Administered by ADH	None
Preventative Health Screenings	All per protocol	PCP or Administered by ADH	None
Durable Medical Equipment	Medical Necessity $500 per state fiscal year (July 1 through June 30) minus the coinsurance	PCP Prescription	20% of Medicaid allowed amount per DME item
Prescription Drugs	Medical Necessity	PCP Prescription	$5 per prescription (Must use generic and rebate manufacturer, if available)
Outpatient Mental and Behavioral Health	Medical Necessity $2,500 per state fiscal year (July 1 through June 30)	PCP Referral and Prior Authorization	$10 per visit

ARKids First Medical Care Benefits (Continued)

Program Services	Coverage Limits on Benefit	Prior Authorization/ PCP Referral	Copayment/ Coinsurance
Chiropractor	Medical Necessity	PCP Referral	$10 per visit
Podiatry	Medical Necessity	PCP Referral	$10 per visit
Nurse Practitioner	Medical Necessity	PCP Referral	$10 per visit
Nurse Midwife	Medical Necessity	PCP Referral	$10 per visit
Federally Qualified Health Center (FQHC)	Medical Necessity	PCP Referral	$10 per visit
Rural Health Clinic	Medical Necessity	PCP Referral	$10 per visit
Family Planning *	Medical Necessity	None	None
Ambulatory Surgical Center	Medical Necessity	PCP Referral	$10 per visit
Speech Therapy	Medical Necessity	PCP Referral	$10 per visit
Home Health	Medical Necessity (10visits per state fiscal year (July 1 through June 30)	PCP Referral	$10 per visit
Medical Supplies	Medical Necessity Limited to $125/mo.	PCP Prescriptions	None
Laboratory & X-Ray	Medical Necessity	PCP Referral	$10 per visit
Ambulance (Emergency Only)	Medical Necessity	None	$10 per trip
Emergency Dept. Services			
Emergency *	Medical Necessity	None	$10 per visit
Non-Emergency	Medical Necessity	PCP Referral	$10 per visit

* Vision Care, Dental Care, Family Planning & Emergency Level Services are excluded from PCP referral procedures.

Exclusions

Services Not Covered for ARKids First Participants:
Audiological Services
Child Health Management Services (CHMS)
Developmental Day Treatment Clinic Services (DDTCS)
Diapers, Underpads and Incontinence Supplies
Domiciliary Care
End Stage Renal Disease Services
Hearing Aids
Hospice
H[yperalimentation
Inpatient Psychiatric Services for Under Age 2 1
Non-Emergency Transportation
Nursing Facilities
Occupational and Physical Therapies
Orthodontia
Orthotic Appliances and Prosthetic Devices
Personal Care
Private Duty Nursing Services
Rehabilitation Therapy for Chemical Dependency
Rehabilitative Services for Persons with Physical Disabilities (RSPD)
Targeted Case Management
Ventilator Services

Arkansas ARKids First Demonstration Waiver
Project No. 11-W0011 5/6
Amendment to Item 10 of the Operational Protocol

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In addition to the Accounting and Budgetary Procedures, the Department of Human Services has promulgated the Department of Human Services Financial Procedures which "establishes procedures for all financial undertakings in the Department of Human Services. It is intended for use by all DHS divisions, offices and institutions, both for interacting with the Division of Administrative Services and for developing and executing other internal financial procedures'' (Summary from Manual Transmittal Memorandum dated December 15, 1995). (The Arkansas Accounting and Budgetary Procedures and Department of Human Services Financial Procedures Manuals are available by request.)

Arkansas Medicaid's Fiscal Agent, Electronic Data System, Inc., operates the State's Medicaid Management Information System (MMIS) described in an earlier section of this Protocol. This system follows a general systems design approved by HCFA for the purpose of reporting financial transactions within the Medicaid system. In addition, the newly operational Decision Support System will allow ready analysis of financial transactions within the ARKids First Program, ranging from tracking expenditures to evaluating the utilization of services, the costs and usage of various programs and the overall financial condition of the demonstration.

The Division of Medical Services is responsible for the operation of the program including the financial management of ARKids First. The Division is assisted by the Division of Administrative Services which completes the quarterly HCFA-64 and HCFA-64.9. In addition to the HCFA-64 and HCFA-64.9, the State has planned modifications to many MARS reporting and Decision Support System (DSS) reports to specifically track the financial activity of the ARKids First Program. All changes to the MMIS and contemplated prior to or immediately following the demonstration waiver approval anticipated before September 1, 1997.

Reporting will be submitted quarterly on HCFA forms 64 and 64.9 to illustrate expenditure and incurred claims. A single HCFA-64.9 will be transmitted for each quarter illustrating the actual expenses of the ARKids First program. In addition, a HCFA-64.9 will be forwarded illustrating the incurred claims for ARKids First participants. Each quarter will be updated in subsequent quarterly submissions to illustrate the preceding quarterly incurred amounts. In addition to these quarterly reports, two consolidated HCFA-64.9 reports will be transmitted following the end of each waiver year, one illustrating the total expenditures during the waiver year and the second illustrating incurred claims by waiver year. The latter report will be updated annually as additional incurred claims are identified. A quarterly HCFA-64.10 will be transmitted quarterly to illustrate administrative costs of implementing the program. (Administrative costs will not be added to the benefit costs for purposes of determining cost neutrality.) All reports will indicate the full Waiver Number and a two year suffix indicating the reporting year of the waiver (Example: 1 1-W-00115/6—0 1 for the first waiver year)

Additional financial information similar to that submitted as part of the waiver application to illustrate budget neutrality can be produced on an "as-needed" basis.

Eligible members will be reported in the format illustrated in the following table shell. Member months will be determined by adding the number of eligibles at the end of each month to an aggregate for each reporting period.

ARKids First Waiver Population **Date Printed** 10/8/97
Number of Eligibles at the end of **Each Stated Month**
Waiver # **11-001*1516***

Month	Waiver Year #1	Waiver Year #2	Waiver Year #3	Waiver Year #4	Waiver Year #5
September					
October					
November					
December					
January					
February					
March					
April					
May					
June					
July					
August					
Total					

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